FEBRUARY • 1948

# the CHILD

# YOUTH AND THE EMPLOYMENT SERVICE

***ROBERT C. GOODWIN,***
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EACH YEAR more than a half million boys and girls join the labor force.

These youths include our future artisans, merchants, and professional groups. They are the leaders of tomorrow. The future of our economy and political existence rests in their hands. Let no one tell you that because they constitute such a small fraction of our labor forces they are unimportant. They and other youths who will join their ranks will constitute almost a third of our labor force 10 years hence.

What in general are the characteristics of these entrants? During the past year new entrants in the labor market have included a high proportion of veterans, youths who have had their civilian careers interrupted by military necessity. Some of these, because of aptitude, interest, or other abilities, have received training that will be vocationally useful in their civilian work. Others have been trained primarily in the art of war and find that they have to start anew upon returning to civilian life. Some of the veterans have not immediately entered the labor market, but have taken advantage of the benefits of the Servicemen's Readjustment Act. One million, one hundred thousand are enrolled in our schools to complete their interrupted training. These will be entering the labor market during the next several years. That 11,310,000 World War II veterans have found gainful employment speaks well of the resourcefulness of our country.

### Will newcomers keep jobs?

During recent months we have been in a period of high national employment. Close to 57 million people are now working. Seasonal employment in agriculture is on the upswing. But the demand for workers in nonagricultural employment has slowed down. The big question now is whether employment expansion in such lines as construction, agriculture, and food processing will overcome the slack which is beginning to appear in other segments of our economy.

The maintenance of high national employment is essential, not only for high production and prosperity, but for the proper placement of veterans, youth, and other entrants into the labor market. If employment slacks off as a result of soft spots in our economy, veterans and young people will be the hardest hit. They are the workers of least experience and the least seniority, and in general will be the first to lose their jobs.

The youth entering the labor force in the next few months will come primarily from the schools. Some will be graduates and some drop-outs. Many will be untrained and undisciplined in the world of work. Some will have learned (or will quickly learn) simple skills that fit them for immediate employment. Because of the temporary economic advantages of employment in occupations requiring little skill, many of these new workers will find employment that will not lead progressively to better paying jobs.

It is this group that offers a special challenge to the public employment service. It is of the greatest importance that these new entrants into the labor force be directed to employment that will consistently and constructively use their potential capacities. In cases where they fail to get off to a good start, the Employment Service must assist them to shift out of blind-alley jobs into occupations with a future.

In approaching the employment of nonveteran youth, we must clearly recognize that school graduates and drop-outs will force increasing competition for future jobs. The backlog of youth who left school during the war and accepted the best-paying jobs (the ones in which they were most needed in the war effort) will face special problems in making a permanent readjustment. The veteran youth, still to be demobilized, will also have special problems in that they are older than the usual new entrants into the labor market. Some of them have married, or will marry

**Like many others, Bill left school for a good job. But times change, and now his job isn't much.**

**Excerpted from speech made at the thirty-fourth annual convention of the International Association of Public Employment Services, held May 26–29, 1947, at New York City.**

in the near future, and they carry additional responsibility not usually attached to the entry worker. The plan for serving youth must be based upon accurate knowledge concerning the needs of the entire group and in addition be geared to the varying needs of the individual.

If a youth program is to succeed, local employment offices, in addition to providing placement and employment counseling services, must assume leadership in organizing community facilities to advance the employment interests of young people. Specifically, local employment offices must provide information to training agencies on employment trends and the requirements of occupations to assure the development of training programs geared to the needs of the labor market; they must supply tools and information to the schools and other agencies useful in providing realistic vocational guidance; they must provide information on occupational requirements and opportunities to student and teacher groups prior to graduation; they must develop an understanding by the students, teachers, and other community groups of service available to youth in the local office; they must secure from the schools and other agencies information needed for counseling and placement to supplement that provided by the applicant; and they must assist employers in identifying entry occupations and promoting their acceptance of beginning workers.

To assure that each local office program is realistically geared to the needs of the community it serves, periodic analyses of the number and characteristics of young applicants seeking work through the employment office should be supplemented by a similar study of those leaving school. On the other side, the employment office will need to know how the job openings available in the community compare with the qualifications and requirements of young jobseekers.

Important among our resources for assisting youth is our vast supply of sound occupational and economic information. We have made vast strides in these fields during the war years. We have established a body of materials and experience which will stand us in good stead in assisting youth in resolving their employment problems in the years to come. On the basis of current labor market information we are able to assist young people in relating their interests and aptitudes to current and potential job opportunities, in order that they may avoid the pitfalls which are inevitable if sound information is lacking.

One of our newest tools for assisting youth in selecting and finding employment which will take full advantage of their interests and aptitudes is the general-aptitude test battery, currently being introduced into the 1,800 local offices. With this new aptitude test battery it is possible to analyze aptitudes in relation to 2,000 different occupations. Scores made on these tests by young people seeking guidance can be compared with the scores made by successful workers in 20 different fields of work. The probability of the youth's succeeding in each field may be accurately evaluated.

**Ida is fortunate to have found steady employment soon after she graduated from high school.**

### Students discuss employment

There is one other phase of community counseling activities which, though still in an experimental stage, I should like to mention briefly. Its objective is to effect the fullest possible gearing together of school guidance activities and the employment counseling function of the public employment service. Many communities are experimenting with programs which hold considerable promise. Briefly stated, these programs provide that, during the junior and senior years of high school, the school holds group discussions which explore in rather general categories the so-called "world of work." These divisions separate into the white-collar occupations, including clerical and sales activities, the trade and service fields, and the industrial field subdivided into skilled, semiskilled, and unskilled categories. During the study of each of these divisions, the local employment office, represented by a labor market analyst, an employment counselor, or a placement interviewer, is requested to provide information covering the kinds of jobs found in each of these groups, the basic requirements of these groups in terms of physical capacities or academic background, the general nature of the work and current information concerning supply and demand in these broad fields.

In successive sessions the students are "polled" to see which of the fields represent the greatest interests of the group. These are in turn subjected to more detailed analysis. Again, employment-office personnel are requested to participate, and full use is made of available literature, motion pictures, and other educational aids.

The advantages of such cooperative

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# How Can Your Community Plan For the Care of Children in Hospitals?

***MARTHA M. ELIOT, M. D.,***
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HOSPITALS have had over the years a deep sense of their obligation to render to the community the kind of service it needs. This concern with what the community needs and wants for its children is also close to the heart of the Children's Bureau.

We have about 42 million children under 18 in the United States—one-third of our population. These children, who hold in their hands the future of this Nation, are the most vulnerable group in their health and welfare needs. The incidence of sickness among those under 18 is higher than for any other age group except people over 64.

But if we are to have healthy children, we must begin with the care that the mother gets during pregnancy. Babies should be born in hospitals where all the facilities for providing the needed care is at hand. We know, for instance, from records of hospitals that have developed services providing medical and nursing care for premature infants, that many infant deaths due to prematurity are preventable.

In 1946 almost 80 percent of the births in the United States were in hospitals, as compared with 37 percent in 1935. States vary a great deal, however, in the percentage of births in hospitals. In 1944, the range was from 98 percent in Connecticut to 31 percent in Mississippi. It is now an established fact that when funds become available to pay for care, and the State and local health departments register the cases and plan with family physicians and hospitals, the percentage of births in hospitals increases. In 1944, in Mississippi, for instance, 73 percent of births under the Emergency Maternity and Infant Care program were in hospitals, in contrast to the 31 percent of all births in the State.

It is difficult, if not impossible, to obtain information on the number of sick children who now receive hospital care.

National medical and health organizations, however, are aware of the lack of information. In order to obtain more specific data, the American Academy of Pediatrics decided in November 1944 to make a Nation-wide study of the health and medical services being given to children. The Academy requested the cooperation of the U. S. Children's Bureau and the U. S. Public Health Service in making this study, which covers four major fields: (1) Pediatric education; (2) distribution and activities of professional personnel; (3) hospital and clinic facilities; and (4) community health services for children. From this study we shall get information on the number of children admitted to hospitals of various sizes in different areas, as well as the number of days of care given to children; and information on the number and qualifications and training of physicians and nurses and others on the hospital staff who care for children. This will provide us with knowledge that we have not had before and that is essential to our planning for the medical and hospital care of children.

Furthermore, data from State surveys of present hospital facilities that will be completed to meet the requirements of the Hospital Construction Act will soon be available. Every effort is being made to combine and correlate this material with the findings of the American Academy of Pediatrics.

We are thus seeing at this time a convergence of effort to get the information that is essential for sound community planning—whether National, State, or local.

I should like to call your attention to another source of help in community planning. Since 1936 State health departments and State crippled children's agencies, in an effort to improve the health of children, have been drawing up annual plans of operation to qualify for Federal funds under the maternal and child-health and crippled children's programs provided for under title V of the Social Security Act. In all these, planning for hospital or convalescent home care figures largely.

The purpose of these programs is to improve, develop, and extend health and medical services to children. The State agencies determine the need for funds and submit plans to the Children's Bureau for furnishing services to children.

Next let us name certain underlying principles or conditions which should govern community planning for the hospital care of children, principles that have impressed themselves on us as these Federal-State cooperative services for children have developed. First, the most obvious: Health and medical services, to be of the greatest use to the individual child, must be accessible to him and they must be complete. Surely there should be a doctor within reason-

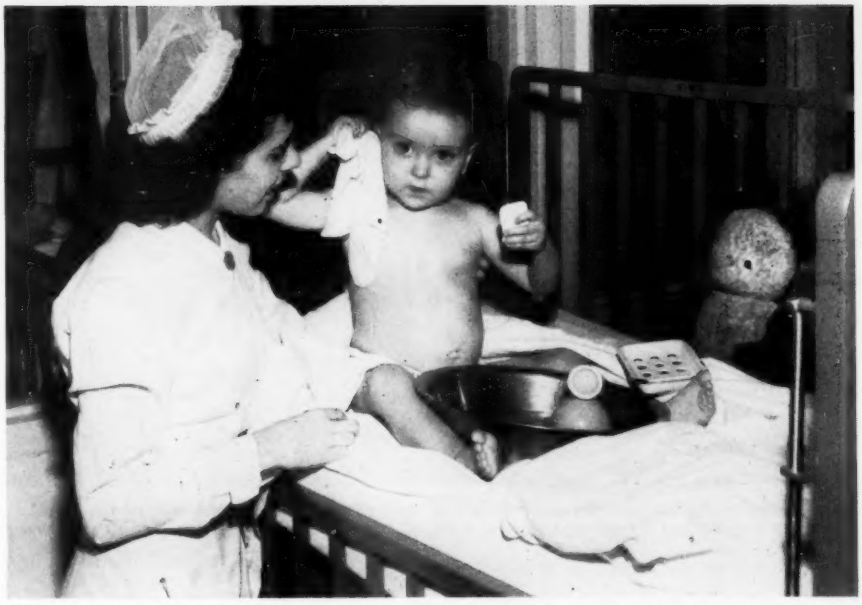
**David is being cared for in the pediatric unit of a hospital. In this unit each bed is in a cubicle with windows, through which the nurse can see the children and they can see one another.**

able reach of every child, and a hospital for the child's care as necessary—one that his parents can reach readily by the usual method of transportation. Where specialized pediatric and other medical service cannot be provided in his local community, there should be a plan for taking him to the place where it is available, or perhaps bringing it to him in special clinics or by a special consultant service.

Preventive, diagnostic, treatment, and after-care services should be integrated into a unified plan to meet the needs of the individual child. The chain of medical and hospital care provided in both smaller and larger communities should make available all the services essential for the adequate treatment of each condition, no matter how difficult of diagnosis or treatment. This requires the services of general physicians and specialists, nurses, nutritionists, medical-social workers, and workers in allied professions. In addition, recreational and educational services, child-welfare services, and any other services necessary to restore a child to full health must be available. The hospital will, of course, work with many other agencies, public and voluntary, in trying to reach this objective.

Secondly, experience has shown that in general the most economical method of providing hospital care for children is in special pediatric units within general hospitals of 50 or more beds. In small general hospitals with fewer than 50 beds, special arrangements for separate care of children should be made possible on a flexible basis.

Special children's hospitals as a rule are virtually general hospitals, self-sufficient in staff and equipment. They have played and still play an important role in establishing standards of care and integrating a diversity of services that are necessary for a well-rounded service to children. It is likely, however, that fewer such hospitals will be built in the future, as most communities find it too expensive to provide, in a special hospital of this type, the whole gamut of services necessary to treat the many conditions that affect children. When large communities can afford to build and maintain general hospitals for children only, there would seem no reason why this should not be done, particularly where the medical staff and all other persons involved in giving services can be integrated with the staff and the teaching program of a medical-school center.



**In the same hospital, a nurse well trained in pediatrics is bathing Jeanne. Such a nurse plans her care of children in a way that will encourage each child's individual development.**

Next I should like to point out that extension of hospital facilities for children in urban areas where already several hospitals exist will require careful planning in relation to the needs of each community and the special conditions that must be provided for. Providing hospital care for children is not just a matter of beds. Any extension of facilities needs to be planned where the services of physicians and others qualified to treat children are, or can be made, available. Early attention should be given to strengthening pediatric units now existing in communities where there are physicians with special training for the care of children. Other units, however, should be developed as need for them is shown, taking into consideration the population to be served, the accessibility of the proposed unit to the homes of the children and to other similar pediatric services, and the availability of professional services that will insure a high quality of care.

My fourth point also is obvious. Care for the ambulatory child patient and the convalescent child should be of as much concern to hospitals and the community as is the care of children requiring bed care in a hospital for acutely sick children. Communities and hospitals must concern themselves with providing facilities for ambulatory care in clinics and the services of skilled physicians and specialists to furnish the care and to offer consultation services to physicians in general practice.

**Given at the annual meeting of the American Hospital Association. St. Louis, September 23, 1947.**

### For long-time care

More adequate provision for convalescent facilities for children who do not require the many services of a general hospital is another aspect to which more thought and planning must be given. We now know something of the numbers of children with chronic conditions who need care and we know that many are not receiving the care they need. But if we had data on the number of children now in hospitals whose condition would permit being cared for in convalescent facilities, better use of the beds now available in general hospitals could be made. Many of these children would be benefited physically or from a psychological viewpoint by being moved from the hospital to a good convalescent facility that is well-equipped and well-staffed to meet the requirements of children under long-time care. Such care in a convalescent home would have the

**An orthopedic surgeon, internes and nurses join their efforts to give this child the best of care. And they are backed by other workers, such as medical social workers and nutritionists.**

added advantage of being more economical to furnish.

These facts are well known to State health agencies and other agencies that administer services to crippled children. Any planning for the care of this group of children should be undertaken in cooperation with these agencies. Furthermore, guides in convalescent care have been worked out by a committee of the National Society for Crippled Children and Adults, in which the Children's Bureau has participated. Architectural plans for children's convalescent homes developed by this committee in cooperation with the architectural services of the U. S. Public Health Service are now available.

A convalescent home should preferably be developed in connection with a general hospital, both functionally and under its administration, to assure adequate direction of medical, nursing, and other professional services of high quality. It is desirable to have the convalescent home removed from the environment of the general hospital but not so far away as to be inaccessible to the general hospital. It is thought that a convalescent facility should not be smaller than 50 beds or larger than 100 beds—large enough to be economically operated, and so operated that the atmosphere of a home will be retained.

Community planning for any kind of hospital or convalescent care for children should obviously take into account standards that have been established for their care. The Children's Bureau has brought together available information and has set forth in its publications standards for various types of care in hospitals, including maternity care, care for the newborn infant, and also for the premature infant. The Bureau is interested in methods of maintaining pediatric-nursing standards. A study of pediatric nursing is now under way to develop a basis for determining these standards.

With respect to standards for medical care of children in hospitals or convalescent facilities, we believe that every child, whether a medical or a surgical patient, should come under the care or supervision of a physician who has had special training and experience in the medical care of children. When this is impossible, pediatric consultation service should be a part of the child's medical care by the hospital. This presupposes that a qualified pediatrician would be on the hospital visiting or consulting staff and always accessible for consultation to the private or other staff physician caring for a child.

### For rural children

It is evident that to attain this standard it will be necessary to have pediatric services available to small communities and rural areas. This will mean developing an interrelationship between hospitals in the large centers and those in outlying communities. Such a relationship will make practicable a flow of professional consultation from the larger medical centers to the small community and rural hospitals and to itinerant or rural health clinics.

We know how to give good care to children, but we have not devised the ways and means to make it accessible and available to all families. Hospitals and health centers have been lacking. Economic and geographic barriers stand in the way. Tradition, too, has established barriers that figure largely in discussions among the professions and among the people. On both sides some traditional practices, though certainly not all, must be replaced with new ones. For instance, if care of high quality is to be made available there will have to be great extension and improvement of practice in groups whether in a hospital and clinic setting comparable to that in many hospitals today or in the setting of a privately organized group of physicians who are banded together to improve the care of their patients. Both these methods of group practice are well known today, but do not exist everywhere. Any group practice should include not only general family doctors, but also the specialists needed by the average family at frequent intervals, such as the pediatrician, and they should have access to complete clinical facilities, including hospitals.

The family doctor in our smallest towns and villages should also belong to such a group, even though the specialists of the group and the hospital and the diagnostic clinics are located in a centrally situated town and the general practitioners are located on the periphery. Under such arrangement the group practice must exist in fact and not in name only if the children in rural areas are to be served adequately. There must be a two-way exchange of consultation and service between a rural or small-town family physician and the central headquarters staff of the hospital and clinic. The community child-health service and the local health centers should be connecting links in the chain that binds rural physicians to the central group.

To make such a plan of small city and rural group practice work, hospitals and clinics, health centers, and child-health clinics must be constructed and equipped in many areas. The Hospital Construction Act now provides the means for making such a plan possible.

To bring services of high quality to

the small communities and rural areas, it is easy to visualize a chain of hospitals and clinics and health centers in every State, developed in accordance with its own particular circumstances. The chain of hospitals would reach from the large medical center to the large-community hospital, and on to the rural hospital and health center. Diagnostic and consultation services, and treatment that could not be provided in the rural or small-community hospital, would be obtained at the larger medical center. There could be itinerant diagnostic and health services to reach out into communities too sparsely populated to warrant permanently established clinics. These could also be connected with the chain of health centers, hospitals, and clinics, reaching back to medical centers. In my opinion the links in this chain will have to be forged together by the State and local health agencies who carry the public responsibility for seeing that the health interests of all the people of the State are served.

It is clear that in any planning for care of children in hospitals, the medical-school hospital is an important center to which outside communities must be able to turn. The teaching medical center must collaborate with State health agencies in taking responsibilities for promoting, developing, and improving health and medical services as far out as there is need for its services. The medical-school center is facing the day when it must join in taking such leadership by extending its knowledge, its skills, and its opportunity to stimulate higher standards in the fields of public health, medical care, nursing, and all the allied professional services involved in safeguarding and restoring the health of children and adults.

### Comprehensive project reported

The program that has been developed for the care of children in the Upper Peninsula of Michigan is an example of the coordination of services that other communities could well study. A report of this was given by Dr. Moses Cooperstock in *The Modern Hospital* for May 1946. The report brings out how the department of postgraduate medicine stimulated a cooperative endeavor that promotes educational aims and opportunities for training, offers the medical services of a pediatrician of faculty rank from the medical school to the children in the Upper Peninsula, and makes diagnostic and treatment services available.

This Child Health Project at Rochester, Minn., demonstrates how services to the children of a community were assumed as part of the responsibility of a large teaching clinic. This is an integration of the efforts of local health and school officials, with the financial support in this case of the Mayo Foundation, the cooperation of the University of Minnesota's Medical School, the School of Public Health, and the Child Welfare Institute. This project is set up as a unit of the section on pediatrics at the Mayo Clinic. Here is a community health program that takes into account not only a child's physical health and welfare but his basic emotional needs as well.

At the heart of the planning for any program of care for children is the training of physicians and other workers in pediatric care, including training in the mental-hygiene aspects essential to good pediatric practice.

Adequate training in pediatrics for all nurses includes consideration of growth and development as well as the study of clinical conditions in children. Nurses preparing for positions in public work should be given additional opportunity to practice, under qualified supervision, the application of the principles of child care in a variety of situations, including those usually met in a broad program of community service. Consultants, instructors, and supervisors responsible for development of educational or service programs should have demonstrated professional competence in the care of children as well as having completed an advanced program of study in pediatric nursing.

In planning community health services for children, it has already been pointed out that the consulting services of pediatricians should be available for areas where there are no physicians especially trained in child care. Consultation services to hospitals by other types of consultants, nurses especially trained in pediatrics, nutritionists, and medical-social workers with basic knowledge of the health and social needs of children, are being developed by an increasing number of health departments.

Already, in 26 States, health departments have created positions for hospital consulting nurses on their staffs to improve maternity care and care of newborn infants. This pattern could be extended into the field of pediatrics with far-reaching benefits to children.

At present only a small proportion of hospitals have trained medical-social workers on their staffs. As with other professional personnel, there are not now enough of these trained workers to provide the services needed. Careful planning is required for the most effective utilization of those we now have and at the same time for the training of

*(Continued on page 126)*

**These children are having fun while receiving long-time care in a convalescent facility. If such facilities are well equipped and well staffed to meet children's needs, better use may be made of the beds in general hospitals and—more important—many children will benefit.**

# PSYCHIATRIC TEAM HELPS DISTURBED CHILD

***HENRY H. WORK, M. D.*** *Director of Mental Health Unit, U. S. Children's Bureau*

THOSE who work in fields that serve mothers and children, whether concerned with medical or social problems, are constantly aware that many things interfere with the smooth functioning of what should be a normal relationship. As a result problems arise which may alter the child's entire life and certainly affect seriously his personality development.

The past 40 years have seen a marked increase here in the United States, both in recognition of the child's difficulties and in means of coping with them. The growth of services to diagnose and treat personality disorders has taken many different routes; they include psychological services, habit clinics, child-guidance clinics, formal psychiatric services for children, and, finally a spread of psychiatric knowledge to the field of pediatrics, with extension to services concerned with prevention.

### Began with backward children

The child-guidance clinic, regardless of nomenclature, has its roots in the many attempts to classify the functioning ability of feeble-minded children, largely on the basis of the possibilities of educating them.

A more recognizable origin for the present-day clinics is Dr. William Healy's work in Chicago in 1909. At that time, when Healy began to work with boys referred to him by the juvenile court, he introduced more dynamic concepts of the problems presented by the behavior of the children. His work set an example for the thorough study of the total make-up of these boys and gave a new conception of the workings of the individual. Healy was far in advance of his time, and there was little in the way of supporting services to aid him.

Ten years later there were only 7 clinics in the country for psychiatric work with children, but so great was the impetus of these that by 1939 there were 776 such clinics.

Along with this numerical growth there have been changes in the organization of clinics and a shaping of the personnel groups to fit the needs of the community that the clinics serve. These changes have been evolutionary, but at present the clinics are mostly centered around the pattern of what is known as the mental-hygiene clinic team, consisting of the psychiatrist, the psychologist, and the psychiatric social worker.

### Psychiatrist directs clinic

The basic member of this team is the psychiatrist himself. Although there have been many clinics where members of other disciplines have played the greater part in organization or function, it is now well-accepted that the psychiatrist holds the responsibility for the plan of treatment of the children and for the diagnosis, based on his fully adequate knowledge of disease and disease processes. He alone has the medical background to see the complete individual and to evaluate the complex interaction of related disease conditions.

In most present-day clinics the psychiatrist acts as the medical or clinic director and supervises other members of the staff in their therapeutic procedures. On him also falls the job of teaching, especially the teaching of other physicians, a service that has always been an essential part of the clinic program.

Complementing his activities are those of the two other branches of the field which make up the team, the psychologists and the psychiatric social workers. Although child guidance began in the psychological study of the feeble-minded, later the practices of the psychologists proved to be of utmost importance in understanding the problems of the child in relation to his abilities. Introduction of the Binet-Simon test in 1908 spurred the activities of this group, and over the years their professional standing has increased and has lent a wholesome and critical adjunct to the psychiatrist in solving the problems of his patients.

At the present time, with a battery of testing material at their service and with a more thorough clinical knowledge of personality types, they are able to contribute enormously to the study of the disturbed child.

The third member of the team represents the newest of the disciplines, but the group of psychiatric social workers has grown to be both numerically important and of real worth in rounding out the combined functions of the clinic team.

Very early in the history of medical social work a few of these workers began to concentrate their efforts upon mental patients cared for in hospitals and clinics. As mental hospitals progressed, changing from custodial institutions to hospitals for the study, treatment and prevention of mental disease, the demand for social work for the patients expanded. However, the main development of psychiatric social services has been in the various psychiatric, mental-hygiene, and child-guidance clinics established to study and treat emotional problems.

Today psychiatric social workers represent an important element in every clinic, being responsible for most of the intake work, frequently handling therapy under the supervision of the clinic director, and maintaining an effective liaison between the clinic and the various independent organizations which the clinic serves. In terms of numbers they usually comprise the largest group of workers in the clinic, and their functions are adaptable to the variety of problems presented for care.

### Teamwork pays dividends

The services which this clinic team has been called upon to perform have been as diverse as the capacities of the personnel and have reflected the variety of origins of its growth. Many of the clinics have not only been set up to meet the needs of a particular demand but have devoted much of their time to the solution of a special mental problem presented to them by a health or welfare agency. In the main, referrals have come from three sources: Health services, social services, and educational facilities, and while some clinics have devoted themselves to working for one of these sources, many of the clinics have served all three.

**Written for presentation at the Ninth Pan-American Child Congress, Caracas, Venezuela, January 5–10, 1948.**

In discussing the referrals that come primarily from the field of medicine itself it is curious to observe that guidance facilities often have had more difficulty in obtaining this type of referral than many others. In the present organization of clinics it is felt that the proper referral is from another physician, but often it was necessary for the clinic to prove its abilities before it could receive such referrals.

However, many physicians, especially pediatricians, now make wise use of the clinic's services. In many privately organized clinics the bulk of cases come from private physicians who recognize that the nervousness of a child is a symtom of a deep personality disorder and that the child needs the diagnosis and treatment which the clinic can provide. In public-health organizations both doctors and nurses were quick to see the advantage of these clinics for children whose symptoms were often those of organic disease but who presented no specific disease process and who later showed emotional difficulties. In this connection it should be mentioned that the clinics early demonstrated the marked correlation of emotional difficulties in the child with those in the parents and shaped their organizations so that they did not deal with the child alone but included the mother either in actual treatment or in a supporting role.

Organized health services gradually became aware of the possibility of using various members of the clinic team as consultants on their less serious problems; and in many areas where there was a dearth of personnel the clinic team functioned almost wholly in a consultative capacity, advising the medical and nursing personnel on specific cases. The psychiatric team has also been of great service in educating the members of the medical profession in a better approach to the child; in particular in their relation to him in the clinic, but in general in all their relations with children.

At all times in the history of development of social services for children there has been a keen understanding of the benefits of the psychiatric approach in case work and in the ordinary dealing with clients. No group has been so aware as the social workers of the possibilities of the guidance clinics and so eager to use them. It has been noted that throughout its history the National Conference of Social Work has presented on its programs psychiatric and mental-hygiene material, and throughout the social-work field there has been active use of clinics and their personnel.

In this field the use of the consultant has been carried to the point of perfection, and in some of our States the only psychiatric service provided for children has been in the form of traveling clinics advising child-welfare workers in the handling of their cases.

In the larger cities many agencies have retained individual psychiatrists as consultants and have used the clinics for their more seriously disturbed cases. In this general area one must consider work with the juvenile delinquent. In many cities there has been an intimate tie with the probation officers and court social workers so that the management of these children has been placed on a clinical basis, and a considered and intelligent approach to the problems of the delinquent child has been obtained. As was mentioned earlier, Healy's first work was with delinquents, and there has been a continual use and sharpening of the psychiatric resources bearing on this problem. At present the trend in this field lies in preventive work, and here again the clinic has been able to give wise counsel.

### For disturbed school children

The abilities of the clinic were early and consistently tested by children whose difficulties first manifested themselves in the school situation. The schools have always remained a steady source of referrals, and much specialized work has been done with children whose problems were directly related to scholastic hazards as well as those whose difficulties antedated their school careers but whose symptoms were overlooked by parents and brought to light by a more observant teacher. In many cities the school departments have brought the clinic team into the school system and have rendered extensive diagnostic and therapeutic service to emotionally disturbed children. The psychologist has been prominent in this role, and both the psychologist and the psychiatrist have been successful in handling children with special educational problems where the fields of medicine and education overlap. Again in the educational field there have been problems in educating the members of the teaching profession itself to make them aware of their responsibilities toward children and of the actual psychological components of the teaching process. This area still requires much study and work and is another strain on the all too meager resources of the clinics.

The most hopeful aspect of the field of psychiatry for children lies in the expansion possible under the National Mental Health Act, passed to stimulate research, training, and services in the field of mental hygiene. When the full purposes of this act have been realized the adequate fulfillment of the mental-hygiene program can be anticipated. At present two important aspects of this program, that of research and that of training new personnel, are operating.

### Professional standards set

Training for the separate disciplines follows definite outlines. The National Advisory Mental Health Council has set minimum qualifications for these positions, as follows:

The physician must first be a graduate of an approved medical school and have completed a year of general internship. This is followed by 3 years of further hospital work in the field of psychiatry, with some training in child psychiatry and then 2 years of practical experience, preferably in a guidance clinic.

The psychologist's training includes both undergraduate and postgraduate work in the specialty leading to a master's degree, plus 2 years of experience in an actual clinic, 1 of these years being supervised study.

The requirements for a psychiatric social worker include approved postgraduate work in this specialty, plus 1 year of full-time experience in social case work in a health or welfare agency with acceptable standards. An alternate requirement is completion of a 2-year course in social case work plus 1 year of experience of the type just described, under the supervision of a qualified psychiatric social worker.

All this training heeds the important factor of working as a group to mold the three professions into a well-functioning and effective clinical team.

**Reprints available in about 5 weeks.**

# TO SAFEGUARD CHILDREN PLACED OUTSIDE THEIR OWN STATE

*I. EVELYN SMITH,*

*Consultant on Foster Care, Social Service Division, U. S. Children's Bureau*

WHEN A CHILD is taken from one State to another to be placed in foster care, he faces greater hazards to his welfare than if he were placed in his own State. And the social agency in either State that is responsible for his welfare finds all the usual difficulties caused by taking a child out of his accustomed way of life, plus some additional complicated ones.

Sometimes the child's new home is a long way from the former one; and distance itself may add to the child's emotional disturbance. Distance may also make it more difficult for the welfare authorities in the child's home State to protect him.

Arrangements have to be made for supervision of the child in the new home, and matters often become complicated when several agencies—State and local—have to take part in the placement.

One of the most important difficulties is caused by a requirement in some States that a child cannot be supported at public expense unless he is a legal resident of the State. As a rule, a child has his legal residence in the State where his father lives, and a child born out of wedlock has legal residence in his mother's State.

Sometimes a child is deprived of proper care by requirements concerning residence. For example, Jimmy, aged 4½, is mentally defective and needs institutional care. But he cannot be placed in a public institution in his State because of a technicality concerning his legal residence.

Jimmy's mother was unmarried, and during her pregnancy she left her own State and stayed at a maternity home in a neighboring State. After Jimmy was born she requested the maternity home to place him for adoption, and returned to her home State.

The maternity home placed Jimmy with a couple in a third State. But soon Jimmy showed signs of mental defect and the couple decided not to go through with the adoption. The maternity home then placed him in a boarding home, where he still is, in a very unsatisfactory situation. The boarding mother is old, is unable to give the child satisfactory care, and does not wish to keep him. His mother pays his board with great difficulty.

When the public-welfare department learned of this situation, it tried to get court action to place Jimmy in a public institution, but could not, as the court considered him not a legal resident of the State, but of the State where his mother lives. His mother's State will not accept responsibility for Jimmy, as he has never been in that State, and the State of his birth also disclaims responsibility.

Besides the difficulties caused by restrictions concerning the child's legal residence, there are problems due to differences in the States with regard to material matters. Resources, financial or other, that were available in the child's home State may be very different in the new State. One State may have, for example, better opportunities for children to live in family homes.

An example of a child's life being changed for the worse by a necessary removal to a State of poorer child-welfare resources is the story of Mary.

Mary was born after her father and mother had separated. Her mother kept her for a year and then paid her board in a family who loved the child and where she was very well adjusted. She went to school with the other children in the family and the neighborhood and was happy.

Then, when she was 8 years old, her mother disappeared. The foster family could not afford to support Mary, and the welfare authorities took steps to provide for payment of her board from public funds. But they soon learned that Mary's father was living in another State, which was therefore the child's legal residence. Although Mary's father was unable to support her, she had to be removed to his State, and the only provision that the State could make for her was in a public institution.

With the idea of exchanging experiences on problems like these, and the even more complicated problems of international placement of children, child-welfare workers in a number of States have for some time been expressing a desire for a conference on placement across State lines. Accordingly, members of the child-welfare staffs of the Illinois and Missouri State welfare departments sponsored a Midwest Conference on Interstate and International Placement of Children, which met at Pere Marquette Park, Grafton, Ill., October 6–7, 1947. Child-welfare workers from 13 States attended—Arkansas, Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan, Minnesota, Missouri, Nebraska, Ohio, Oklahoma, and Wisconsin. Representatives of the U. S. Children's Bureau also participated.

### Recent laws stress child's welfare

As a background for the discussion a staff member of the U. S. Children's Bureau presented a summary of State laws relating to interstate placement of children. This showed that most of these laws were passed in the latter part of the nineteenth century and the early part of the twentieth, before adequate State welfare laws provided for the licensing and supervision of agencies placing children. The earlier laws did not take into consideration the idea of cooperation between State authorities, but stressed protection of the State from casual and undesirable placement of children by persons or agencies from another State. These laws were passed to keep the State from having to assume responsibility for support of children from other States. Recent laws, on the other hand, emphasize the child's welfare, and some States have revised their early laws so as to provide protection for the child.

The conference agreed that in order to safeguard the child, as well as the family in which he is to be placed, and the State, the agency that plans to refer a child to authorities in another State for placement should provide a state-

**Every child needs to be with his parents, as these twins are. Many are not; and State departments of welfare are much concerned about these children's welfare and happiness.**

ment of all the essential facts about the case. Such a statement would include the reasons for considering placement of the child in the State, and also information on the child's personality and his most urgent physical and emotional needs. Such information was felt to be essential to enable the responsible agency in the receiving State to study the proposed plans for his care.

When it comes to the actual placement, all possible safeguards should be set up by the two responsible agencies—one in the child's home State and one in the new State—before the child goes to the new home. There should be a clear understanding with respect to the legal guardianship of the child. The family in which he is placed should be told why continued supervision of the child is necessary, and what to expect in the way of visits from representatives of the supervising agency. The division of responsibility between the two agencies should be made clear. The agencies should come to an agreement upon reports to be made on the child's progress and adjustment. Also there should be determination of who will be responsible for the child's support in case he becomes dependent. The two agencies should be clear as to who shall decide when supervision is no longer needed and the procedure to be followed if it becomes necessary to return the child to his former State. If adoption is the ultimate plan there should be an understanding as to which State the court petition is to be filed in, and after how long a trial period.

While it was recognized that the laws of both States must be conformed with, some workers felt that many State laws lag behind present-day philosophy and accepted social practices. This sometimes makes good planning in specific cases difficult. Since existing laws may not be changed soon, liberalizing of existing practices through administrative procedures where possible was recommended.

### Children brought from other countries

The conference reviewed international problems relating to the placement of children in the United States from other countries. Some of the points discussed were admission of European refugee children, adoption of foreign-born children, placement of Canadian children for adoption in this country, bringing to this country children born overseas whose fathers were American servicemen, and caring for repatriated children returned to the United States by the State Department, unaccompanied by parents or other guardians.

Throughout all the discussions at the conference it was emphasized that good standards of work for children should be upheld in all interstate placement and that the welfare of the child should be the paramount consideration.

There was agreement that social services should be given to children on the basis of their own particular needs rather than on the basis of residence, unless the law specifically limits eligibility for services to persons who are legal residents of the State. The conference emphasized that the aim of meeting the individual needs of children could be realized more fully if Federal legislation would provide for financial participation by the National Government through grants in aid to States for foster-family care.

The findings committee was asked by the conference to prepare a draft for an agreement between the State from which a child is removed and the State in which he is to be placed. This agreement should include a statement of basic principles and procedures for interstate placement. It should also include an outline of information concerning the child, to be sent by the referring agency, and of information concerning the family under consideration for receiving the child into their care.

Such an agreement might serve as a tentative draft for consideration by the individual States with respect to the desirability of such agreements on interstate placement and the authority of the State to enter into them.

The findings committee was also requested to explore the question of Federal legislation regulating interstate placement or the possible passage of a Federal law authorizing the individual States to enter into interstate compacts or agreements on a voluntary basis.

The Children's Bureau was requested to (1) summarize in written form information relating to international problems concerning the placement of children, and (2) assist in developing a plan for a statistical study of the scope of interstate placements.

A follow-up conference was recommended for the spring of 1948.

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**"The diversity of social-welfare practices is as great as is the diversity of climatic and soil conditions in the fifty-odd States, Territories, and possessions which comprise the United States. This could not be otherwise because of the different periods of settlement and the variety of backgrounds and economic conditions in the different States."—Emma O. Lundberg: Unto the Least of These, p. 10. D. Appleton-Century Co., New York, 1947. By permission of the publisher.**

# IN THE NEWS

## United States Committee for ICEF Formed

The United States Committee for the International Children's Emergency Fund held its first meeting at the White House, January 19, 1948. This committee is a voluntary association of citizens, formed to advise the United States representative to the Executive Board of the International Children's Emergency Fund with regard to information and suggestions from United States sources regarding the work of the Fund. The membership is broadly representative of a wide range of citizens' groups throughout the country and of geographic areas. The chairman is Mrs. Oswald Lord.

The committee will cooperate with the American Overseas Aid-United Nations Appeal for Children.

Twenty-six nations are represented on the Executive Board of the ICEF. The United States representative is Katharine F. Lenroot, Chief of the U. S. Children's Bureau.

## For Relief of Overseas Children

Individual contributions amounting to at least 60 million dollars are asked from the people of the United States to help meet the most urgent 1948 needs of distressed children and adults overseas.

Similar drives are being carried out in a number of other countries by the United Nations Appeal for Children. In each of these countries a national organization will collect the funds. In the United States this is being done by a campaign organization representing 21 voluntary organizations that are already furnishing relief in war-torn countries, and the United Nations Appeal for Children, whose proceeds in the United States will go to the International Children's Emergency Fund.

AOA-UNAC is strictly a collection agency, and does not itself furnish any food or services. It was formed at the request of the Department of State, in answer to an increasing demand from community leaders all over the country for unification of the many requests for funds.

Thirty percent of the 60 million dollars will be used by the participating voluntary agencies for services to families, medical programs for displaced persons, and related services, many of which affect children as well as adults. Seventy percent will go toward special children's activities—21 million for the ICEF and 17 million for the children's programs of the voluntary agencies.

The national drive has already begun; local drives will begin at various times, according to the situation in the various parts of the country. Many will begin in April. Local committees are being formed to participate in the appeal, along lines compatible with local practice.

Contributions to AOA-UNAC are deductible for income-tax purposes by specific Treasury Department ruling dated October 14, 1947.

The headquarters of American Overseas Aid and United Nations Appeal for Children is 39 Broadway, New York 6, N. Y.

The agencies participating in American Overseas Aid-United Nations Appeal for Children are: International Children's Emergency Fund (United Nations), American Friends Service Committee, Church World Service—Special Projects Division, Unitarian Service Committee, War Relief Services—National Catholic Welfare Conference, YWCA World Emergency Fund, American Aid to France, American Hungarian Relief, American Relief to Austria, American Relief for Czechoslovakia, American Relief for Italy, American Relief for Poland, Greek War Relief Association, Philippine War Relief (of the U. S.) Inc., United Lithuanian Relief Fund, United Service to China, AFL Labor League for Human Rights—Foreign Relief Program, CIO Community Services Committee—Overseas Relief and Rehabilitation Fund, Freedom Fund—Cooperative League of the USA, International Rescue and Relief Committee, International Social Service, Tolstoy Foundation for Stateless Russians.

## Canadians Redraft Model Vital-Statistics Act

Registrars of vital statistics and legislative councils from eight Provinces of Canada met with representatives of the Department of National Health and Welfare and the Canadian Welfare Council December 1–4, 1947, to discuss a draft of a model vital-statistics act, prepared by a committee composed of staff members of the Dominion Bureau of Statistics.

Use of the short-form certificate was urged at the conference; also that birth certificates involving adoption and legitimation be filed at the Provincial rather than the local level. Exchange of adoption data was advocated, not only between Provinces, but between countries, also confidential handling and other procedure intended to safeguard data concerning births, adoptions, and so forth. As for the controversial questions concerning birth registration of allegedly illegitimate children born to married women, there was strong feeling in the group that common-law principles should be upheld.

The model act will be redrafted in the light of the conference discussion and will be submitted to the Vital Statistics Council and the Commissioners on Uniformity of Legislation before transmission to the Provinces. Each Province will, of course, be free to change the model act to suit its own views.

(For discussion of the social aspects of birth registration in the United States see *The Child*, August 1946 and June 1947.)

*SOURCE: Concerning Children. Child Welfare Division, Canadian Welfare Council, Ottawa. December 1947.*

## Nebraska Expands Health Education

Health education in Nebraska is starting on a 3-year expanded program. Sponsors are the State departments of public instruction, of assistance, and of child welfare, in cooperation with the universities and teachers colleges. At each of these centers will be a health educator and a nutrition specialist who will teach and supervise in the area adjacent to the centers. State consultant services will be available as these are needed in the development of the program.

## Films Show State Rheumatic-Fever and Premature-Baby Programs

A motion picture on rheumatic fever and one on premature infants—both for the public—have recently been produced by Virginia's State Health Department in cooperation with the U. S. Children's Bureau. These two films have been financed through use of grants to States administered by the Bureau under the maternal and child-health provisions of the Social Security Act.

Although Virginia is the State responsible for these two pictures, they have been produced on behalf of all State health departments.

The film, "We See Them Through," pictures Rhode Island's State program

for children with rheumatic fever. It shows a coordinated program that brings together medical, medical-social, nursing, and other skills to treat children during the acute stage of rheumatic fever and the long convalescence from this serious disease.

"Starting Line" is the title of the other picture. It shows how the Illinois State Health Department is providing specialized care for premature babies from birth until they can be cared for by their mothers. Eventually Illinois hopes to have a network of premature-baby centers throughout the State for the benefit of all babies needing the specialized services.

The Virginia State Health Department is planning a third film, to be made in cooperation with the U. S. Children's Bureau. This will be on services for crippled children.

## Crippled Children in Uruguay Attend Special School

Special attention to children with cerebral palsy is given at the Franklin Delano Roosevelt School for Crippled Children, in Montevideo, Uruguay, the first school for crippled children in South America. Established in 1941 by the National Association for the Crippled Child in Uruguay, the school admits without charge all children whose parents cannot afford to pay. Such children receive not only schooling, but also medical and dental care and clothing.

## European Children Visit Britain

Many British families opened their homes last summer to children from war-devastated countries in Europe under a plan that begun in the middle of the war. It is the program of the Reception Committee, Young People from Occupied Countries, an organization recognized by the British Government but not subsidized. Under its sponsorship 15,000 private families have given temporary homes to young foreigners since 1942 in an attempt to provide a few months of relief from the miserable conditions of their homes in countries that were occupied by the Nazis.

In selecting suitable homes for the children, the committee writes to the mayor of a given British town, asking whether the community would be interested in offering hospitality. If the reply is affirmative, the mayor sets up a committee (of which there are now 200) of local citizens whose duty it is to select those homes which are most suitable, and to be responsible for the children while they are in residence. The children are divided into groups of 10; an adult accompanies each group from its own country, and keeps her charges under benevolent supervision throughout their stay. In general, the children visit prosperous working people, the local committee doing what it can to see that a child is received at a home fairly similar to that from which he came.

The purpose of the project is to remove the children from scenes of hardship and distress, and to receive them as members of the family in homes where affectionate care, rest, and good nourishment will restore them physically and emotionally. Strictly rationed though Britain is, her fare is abundant by standards in the homes of many of these young war victims. A month in the quarantine camp and 2 months with a British family have, in the past few years, meant much to thousands of young Europeans. Nor have the benefits been one-sided. The hosts have become quickly attached to their guests, and firm friendships have sprung up during the visits.

## Haiti Legislates to Protect Children Employed as Domestic Servants

A law aiming at the protection of children under 18 placed in families for domestic service was passed in Haiti in September 1947.

Under this law, any person who takes a child into his home for domestic service must obtain a permit from the Bureau of Labor and must be at least 21 years old, free from communicable disease, and of good moral character.

Lodging, suitable clothing, and wholesome food in sufficient quantities must be provided for the child, and he must be allowed to attend school at least part time. Semiannual physical examinations at a public-health clinic are also prescribed.

The law prohibits employment of children under 18 as messengers or street vendors or in other similar occupations during the hours when they are required to attend school, or in the afternoon on Sundays or legal holidays, or between 7 p. m. and 6 a. m.

Labor inspectors may visit any home where a worker under 18 years of age is in service, for the purpose of investigating his or her living conditions. If these conditions are found unsatisfactory, the Bureau of Labor may return the child to his family, or, with the consent of the parents, place him with another family or in an institution.

In localities where there is no branch of the Bureau of Labor, enforcement of the law is entrusted to municipal magistrates.

Penalties are prescribed for violation of the law.

*SOURCE: Communication from American Embassy, Port-au-Prince, Haiti, November 11, 1947.*

## • QUOTE-UNQUOTE

"When we had a war to win and conscripted our youth to fight it for us, nothing was too good for them. We gave them first priority on our food and clothing. We taxed ourselves heavily to buy them the best. We provided them with the best training, the finest medical care, and the most expert personal services we could muster.

"Now we have a peace to win, and in labor's opinion nothing is too good for the new generation of children that is going to have to make that peace hold. Our children need—and must have—the best preparation the Nation can devise. That 'best' can be something much better than anything the children of the United States have had before. What's more, it must be!

"Labor is done now with the national mockery that panders to youth in war and penny-pinches children in peace.

"The world over, to grow well, every child needs to belong to a family: (1) That can obtain all the goods that make for the healthy growth and development of a child; and (2) that lives in a community where schools, medical care, and public welfare and recreational services are good. A minority of America's children in the past have been lucky on one score. Only a handful have had the breaks on both.

"Labor's fight for children focuses on both fronts: On building up family incomes to the level where each family can get the goods its children need, and on building up national income so that all communities can have better and better public and private services for children."

**"CIO's Program for Children." In Economic Outlook, Jan. 1946.**

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In the January issue of *The Child* we failed to give the sources that Anna Kalet Smith drew on in preparing her article, "Norwegian Schools Offer Health Services to Children." They are as follows:

*Sources:* "Skolehygienen," by the chief medical officer, Oslo Schools, 1947; articles by Dr. T. Gythfeldt, chief dental officer in the schools of Oslo, published in Den Norske Nasjonalforening mot Tuberkulosen, 1945, and in Sosialt Arbeid, 1943; Social Håndbok for Norge, 1937; and memoranda, issued in 1947, by the municipal school authorities of Oslo.

## Children in Hospitals

*(Continued from page 119)*

additional ones. Plans will have to be worked out in cooperation with local health departments, particularly in rural communities, by which medical-social workers are employed by the community to serve more than one hospital or convalescent facility. More and more State health departments have medical-social workers on their staffs to consult with and help hospitals in planning for medical-social services. This source of help to local hospitals and community groups should be available in every State.

Nearly all State health agencies employ one or more nutritionists. Many of these nutritionists have completed an approved dietetic internship in a hospital. Now that they are in a position to influence community action, they can do much to see that nutritional gains that the patient makes in the hospital are maintained after he returns home. They can also help the hospital dietary staff in teaching both staff and patients because they are familiar with resources and food habits in the patients' homes and in which some of the student nurses and medical internes will work after their training. A growing number of State health departments employ consultant dietitians whose principal activity is to consult with physicians and nurses in hospitals.

We know that public interest in problems concerning the health of children is increasing. There has been a movement in the States for organizing committees, commissions, or councils to assume responsibility for planning health and welfare activities to meet the needs of children.

Hospitals should make it their business to know about such committees and commissions in their State or community. They should be represented in such planning groups so that hospital and convalescent care will be correlated with health service and medical care, with welfare and education in over-all programs to improve conditions for children. Planning is still pioneering and there is need for experimentation in which hospitals ally themselves with all other forces in the community to assure that the needs of children are met.

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## Employment Service

*(Continued from page 115)*

programs are obvious. The school guidance program benefits by the addition of highly specific current information and by the wider points of view expressed by participants who are not a part of the school system itself. The local office benefits by the fact that the student, after graduation or drop-out, comes to the local office already partially equipped with basic information necessary to his final selection of an occupational objective and prepared to explore with the employment counselor the specific opportunities currently available and the relative advantages of different courses of action. If he is considering an occupation for which extensive training or apprenticeship is required, he may already know the extent and kind of this training and will have tentatively explored his ability to enter such a course of training with reasonable likelihood of being able to complete it.

Another area for cooperative planning by school and employment service personnel relates to the particular problem of the individual who, wishing to continue school, must yet seek part-time work and employment during summer vacations. More rapid and effective service to this group may be achieved if the school makes available its physical facilities and can arrange for group registration conducted by employment-service interviewers or counselors, to be followed, if necessary by evenly scheduled appointments at the employment office.

I should like to say in closing that public employment service holds very high hope for the continued improvement in the program for assisting youth to meet their employment problems. You may be sure that the national office will spare no effort in assisting you to keep the program geared to the changing needs of youth. This program, however, can be made dynamic only by local planning based upon careful analysis of the youth being served, what they can offer in the labor market, what the labor market can offer them, and the services which other agencies are equipped to provide.

**Reprints available in about 5 weeks**

## • FOR YOUR BOOKSHELF

OUR RURAL COMMUNITIES; a guidebook to published materials on rural problems, by Laverne Burchfield. Public Administration Service, Chicago. 1947. 201 pp. $2.50.

This book gives a summary, with references, of information needed by persons planning action on rural problems such as those relating to schools, the church, medical care and health services, welfare, housing, recreation, local government, community organization, and land use in the rural community.

Although it is packed so full as to be almost a catalog of essential information, the book is also a stimulus and guide to those who are investigating the resources of the rural community and of the Nation in behalf of the rural community. It is an outgrowth of a brief digest of similar material on current activities of agencies interested in country life, and of literature on post-war planning for rural life, which was prepared for the American Country Life Association conference in 1944.

**Stella Scurlock**

INSTITUTIONS FOR CHILD CARE AND TREATMENT, by Mary Lois Pyles. Child Welfare League of America, 130 East Twenty-second Street, New York 10, N. Y. 1947. 28 pp. 50 cents.

Miss Pyles has here written about institutional work with special reference to case work in relation to other components of the care and treatment of children. She deals with changing attitudes toward children's institutions, the nature of institutional care, some guiding principles of modern institutions, contributions of case work, problems of case work in institutional care, and coordinated child care and treatment.

"It is the group living and group care situation," says the author, "which defines both the limitations and opportunities of the institution. It should be a guiding factor in determining the children who come to institutions and it enters into all efforts to help them."

Since institutional living is not an end in itself for the care of children, Miss Pyles points out that the institution needs to work toward the return of its children to their own homes or to foster-family homes as soon as possible.

It is accepted that institutions are called into being by social problems and have the responsibility of helping

clients reach satisfying personal and social adjustment. As a social agency an institution needs to make use of social-work knowledge and skill in carrying on its work.

The need of the child for case-work service is discussed in relation to his admission to the institution and to his stay there, and also in connection with his leaving. Some institutions may try to add case work as an appendage, without giving it any real place in the life of the institution, but the service cannot be fully effective when given in that way.

There is a continuing need for the case worker, the cottage parent, the teacher, and the recreation leader to consult with one another. Teamwork is essential, but just as essential is leadership for the team from the administrator, who needs to understand the contributions of all parts of the program.

**I. Evelyn Smith**

TEAMWORK IN COMMUNITY SERVICES, 1941–1946; a demonstration in Federal, State, and local cooperation, by Katherine Glover. Office of Community War Services, Federal Security Agency, Washington, 1946. 80 pp.

Among the activities described in this account of a wartime experiment is the Government program for the day care of children of working mothers, which was carried out so far as possible through existing Federal agencies. The Children's Bureau and the Office of Education cooperated with Community War Services in developing policies and procedures for this program. The War Manpower Commission, the Army, the Navy, the Maritime Commission, the Federal Public Housing Authority, and the Federal Works Agency also cooperated in providing this much-needed service for children. The story of this and other services is presented not merely as a historical record, says the report, but also as significant background for the continuing development of community services.

SCHOOL-AND-WORK PROGRAMS; a study of experience in 136 school systems, by Caroline E. Legg, Carl A. Jessen, and Maris M. Proffitt. Joint publication of the Federal Security Agency, Office of Education; and the U. S. Department of Labor, Division of Labor Standards, 1947. 59 pp. For sale by Superintendent of Documents, Government Printing Office, Washington 25, D. C. 20 cents.

Programs combining school attendance with paid employment under which high-school boys and girls are released from some school time to take part-time jobs, gained sudden popularity during the war as a means of meeting demands of employers for young workers and the desire of students to become wage earners as well as to help in the war effort.

This war-born condition created a new interest in school-and-work programs (1) for educators because the realities of employment were brought closer to the school and (2) for those concerned with the protection of young workers because of the necessity for safeguarding the interest of these young people while on the job. Two agencies representing these two groups, the U. S. Office of Education and the U. S. Children's Bureau, accordingly began this joint study of school-and-work programs in 1945. Later the Bureau's Industrial Division became the Child Labor and Youth Employment Branch of the Division of Labor Standards, U. S. Department of Labor, and as such completed the study with the Office of Education.

The report describes the operation of school-and-work programs in more than 100 cities and analyzes their strengths and weaknesses. On the basis of the findings suggestions are made for the use of school administrators who are considering establishment of such programs.

WHEN YOU ADOPT A CHILD. Federal Security Agency, Social Security Administration, U. S. Children's Bureau. Folder 13. Washington, Revised 1947. 24 pp. Single copies free.

This is a revision of the folder formerly entitled "Adoption." It offers answers to many of the questions raised by couples who are thinking of adopting a child.

KEEPING UP WITH TEENAGERS, by Evelyn Millis Duvall. Public Affairs Committee, Inc., 22 East Thirty-eighth Street, New York 16, N. Y. 1947. 31 pp. 10 cents.

Persons who work with adolescents or with the parents of adolescents will welcome this lively, sympathetic description and explanation of some of the challenges offered by the teen age. Harking back to "When You and I Were Young, Maggie," the author shows how the problems that parents get into a stew about are related to the changed conditions under which youth lives today. She makes a good case for greater realization by parents that they need adaptability and capacity for understanding. No one is at fault, she is careful to point out, for the confusion and conflict between the two generations. Recognition of this fact may be the first step in bringing parents and teen-agers closer together.

This brief, readable pamphlet will stimulate many parents to take some of the positive steps toward better mutual understanding that Mrs. Duvall suggests.

**Marion L. Faegre**

Occupational Index, Inc., New York University, Washington Square, New York 3, N. Y., continues to publish six-page leaflets, at 25 cents, giving information on earnings, qualifications, opportunities, advantages and disadvantages, of various types of work. Among the occupations treated in these leaflets are a number that may be of interest to persons who wish to work with children.

The titles of a few of these leaflets, published in 1947, are: Librarian, Medical Secretary, Practical Nursing, and Psychiatry.

## CALENDAR

**Feb. 22–29**—American Brotherhood Week. Sponsored annually by the National Conference of Christians and Jews, 381 Fourth Avenue, New York 16, N. Y.

**Feb. 26**—National Committee for Parent Education. Atlantic City, N. J.

**Feb. 26–27**—Conference on educational and recreational programs for children with orthopedic conditions. Sponsored by National Foundation for Infantile Paralysis. Held in connection with seventy-fourth annual meeting of American Association of School Administrators. Atlantic City, N. J.

**Mar. 1**—Child Study Association of America. Annual conference. New York, N. Y.

**Mar. 7–9**—Ninth Annual Southern Safety Conference and Exposition. Birmingham, Ala. Executive offices, 2120 First Avenue North, Birmingham 3, Ala.

**In Laura, on our February cover, we see the typical American child, healthy and happy. Let us think also of those other children, in war-devastated countries, who are cold and hungry. And let us give what we can toward making life easier for them. The photograph is by Philip Bonn.**

**Credits for other photographs:**

**Pages 114 and 115, by Talbott for Look magazine.**

**Page 117, by Ben Greenhaus for Nursing Information Bureau.**

**Page 118, by Baltimore Sun, for James Lawrence Kernan Hospital, Baltimore.**

**Page 119, by Philip Bonn for U. S. Children's Bureau.**

**Page 123, by Woodrow R. Wilson for Federal Works Agency.**

# We Meet Again With Our Latin-American Neighbors

I have recently returned from the Ninth Pan American Child Congress, which was held at Caracas, Venezuela, January 5–10. I feel that this meeting has set a new milestone on the road to Inter-American cooperation.

It was a great experience to sit down again with representatives from other American nations, all working toward a single goal, the good of children.

The country where we met, Venezuela, is an inspiration in itself. For Venezuela, held back for years by a dictatorship, has made great progress in the last decade in providing for her children—their health, their education, their general welfare.

To Venezuela goes much of the credit for the success of the Congress. The Venezuelan Organizing Committee, under the chairmanship of Dr. Gustavo H. Machado, President of the Venezuelan Child Council, made the arrangements and prepared the program, with the cooperation of the American International Institute for the Protection of Childhood.

The Venezuelan delegation contributed what was perhaps the most important paper presented to the Congress, a statement of principles for legislation concerning the protection and welfare of children, including a declaration of the rights of the child and the duties and rights of the state. This statement of principles, or "children's code," was studied and revised by a technical commission and recommended by the Congress to the American Republics for their consideration, with such modifications as are made necessary by the constitutional system and the social and cultural conditions of each country.

In another important statement, the Congress affirmed the right of children to good health. This declaration will be put into final form by the American International Institute for the Protection of Children, working with the Pan American Sanitary Bureau. It will then be known as the "Declaration of Caracas on Child Health."

The Congress also made recommendations regarding Nation-wide organization and financing of health and social services for mothers and children. Some of its other recommendations concerned nutrition, prevention of tuberculosis, and the care of neglected children.

The child of school age was the subject of broadly conceived recommendations, founded upon the concept that the school is concerned with the well-being of the child in all the aspects of his growth and development. The Congress considered rural, preschool, and progressive education, and also took account of the needs of the child for protection and recreation outside school hours.

In all its recommendations the Congress showed a broad understanding of the close relation between health and social services.

The Congress strongly urged all American Governments and peoples to support the International Children's Emergency Fund and the United Nations Appeal for Children. At the same time it asked the ICEF to take into consideration the needs of the children of the Western Hemisphere, for many of these live in poverty and suffer from undernutrition.

Noting that another important Inter-American meeting is soon to take place, namely, the Ninth International Conference of American States (at Bogota, Colombia, in March 1948), the Congress requested this Conference to give due recognition to the special needs of children and youth. In this connection the Congress also stressed the importance of effective cooperation among the American countries in studying and solving problems relating to the health, education, and social welfare of children.

One trend that was noticeable throughout the sessions was the increased recognition that the Congress gave to the leadership of the American International Institute for the Protection of Childhood. To a greater degree than any previous Congress the Ninth Pan American Child Congress assigned to the Institute important responsibilities to be carried out in the immediate future and later. The presence of the Institute's president, Dr. Roberto Berro, and of its secretary, Dr. Víctor Escardó y Anaya, contributed greatly to the success of the Congress.

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VOL. 12 No. 8 FEBRUARY 1948

# the CHILD

published monthly by the
Division of Reports
U. S. Children's Bureau
Managing Editor Sarah L. Doran
Art Editor Philip Bonn

FEDERAL SECURITY AGENCY
SOCIAL SECURITY ADMINISTRATION

U. S. CHILDREN'S BUREAU
Katharine F. Lenroot, Chief

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Publication of THE CHILD, monthly bulletin, was authorized by the Bureau of the Budget, May 12, 1936, to meet the needs of agencies working with or for children. The Children's Bureau does not necessarily assume responsibility for the statements or opinions of contributors not connected with the Bureau. THE CHILD is for sale by the Superintendent of Documents, Government Printing Office, Washington 25, D. C., at $1 a year, foreign postage, 25 cents additional, single copies, 10 cents.

U. S. GOVERNMENT PRINTING OFFICE: 1948